

Ballard Wright, M.D., PSC (Physician's Practice)
2416 Regency Road, Suite 30
Lexington, KY 40503

Phone (859) 278-1316

Fax (859) _____

Authorization For Use and Disclosure of Protected Health Information

(Form must be filled out in its entirety or it will be returned.)

Patient Name: _____ SS#: _____ DOB: _____

Address: _____ Phone #: _____

COMPLETE THIS PORTION WHEN REQUESTING OUR RECORDS:

The undersigned hereby authorizes Ballard Wright, M.D., PSC to disclose medical information to _____ at _____.
(Requestor) (Address)

COMPLETE THIS PORTION WHEN REQUESTING ANOTHER PROVIDER'S RECORDS BE SENT TO US:

The undersigned hereby authorizes _____ to disclose medical information to Ballard Wright, M.D., PSC [] above address or [] fax number.

Information requested:

- Complete Medical Record
- Office Visits
- Labs*
- Imaging Reports
- Medication Record
- Physical Therapy Notes
- Behavioral Medicine Reports*
- Other _____

Time Period: From _____ to _____

- I understand that the information released may contain information relating to alcohol and/or drug abuse, drug tests and/or lab results, psychiatric diagnoses and/or mental health information, communicable diseases including HIV and other sexually transmitted diseases.
(Must be checked in order to receive this type of information.)

How Disclosed: [] On-site review [] Paper Copies - [] Patient will pick up [] Mail to above address
[] Fax to _____ (healthcare providers only)

Purpose of this disclosure:

[] Request of Individual [] Other _____

I understand that this authorization expires:

- In six (6) months from the date on this form.
- Upon the happening of the following event:
(i.e. upon settlement of workers' comp case, etc.)

By signing this form, I understand that I have the authority to revoke this form at any time by written request to be given to/mailed to Amybeth Dotson, RHIA, Director of Medical Records for Ballard Wright, M.D., PSC at the address listed above. I understand, however, that the revocation of this authorization will not have any affect on actions taken by Ballard Wright, MD, PSC prior to the revocation of this authorization and in reliance of this authorization. I also understand that the information disclosed may be subject to disclosure by the person(s) I have authorized to receive it and that the information no longer is protected by federal privacy regulations. Lastly, I understand that Ballard Wright, M.D., PSC may not condition my treatment on whether or not I sign this authorization.

Signature of Patient/Guardian Date Guardian's Name & Relationship (if applicable)

Witness' Signature Date

The Pain Treatment Center d/b/a Stone Road Surgery Center
280 Pasadena Drive
Lexington, KY 40503

Phone (859) 278-1316

Fax (859) _____

Authorization For Use and Disclosure of Protected Health Information

(Form must be filled out in its entirety or it will be returned.)

Patient Name: _____ SS#: _____ DOB: _____

Address: _____ Phone #: _____

The undersigned hereby authorizes The Pain Treatment Center d/b/a Stone Road Surgery Center, to disclose medical information to _____ at

(Requestor)

(Address)

Information requested:

- Complete Medical Record
 History and Physical Reports
 Operative Reports
 Other _____

Time Period: From _____ to _____

- I understand that the information released may contain information relating to alcohol and/or drug abuse, drug tests and/or lab results, psychiatric diagnoses and/or mental health information, communicable diseases including HIV and other sexually transmitted diseases. (Must be checked in order to receive this type of information.)

How Disclosed: On-site review Paper Copies - Patient will pick up Mail to above address
 Fax to _____ (healthcare providers only)

Purpose of this disclosure:

Request of Individual Other _____

I understand that this authorization expires:

In six (6) months from the date on this form. Upon the happening of the following event:
(i.e. upon settlement of workers' comp case, etc.)

By signing this form, I understand that I have the authority to revoke this form at any time by written request to be given to/mailed to Amybeth Dotson, RHIA, Director of Medical Records for The Pain Treatment Center at the address listed above. I understand, however, that the revocation of this authorization will not have any affect on actions taken by The Pain Treatment Center prior to the revocation of this authorization and in reliance of this authorization. I also understand that the information disclosed may be subject to disclosure by the person(s) I have authorized to receive it and that the information no longer is protected by federal privacy regulations. Lastly, I understand that The Pain Treatment Center may not condition my treatment on whether or not I sign this authorization.

Signature of Patient/Guardian Date Guardian's Name & Relationship (if applicable)

Witness' Signature Date

REVERSE SIDE MUST BE COMPLETED IF REQUESTING OFFICE VISITS, DIAGNOSTIC STUDIES, LABS, OR ANY OTHER SERVICE PROVIDED IN THE PHYSICIAN SETTING.